THREE RIVERS FAMILY MEDICINE

Medicare Wellness Visit

Patient's Name: _____ D.O.B_____/_____/_____ Exam Date: _____

Allergies to Meds: _____ PCP: _____

Past personal illnesses, injuries, operations or diagnoses	Date	Hospitalized?

Tobacco use: YES ☐ NO ☐ (Smoke or chew) packs per day? _____

Alcohol use: YES ☐ NO ☐ drinks per week? _____

Drug use: YES ☐ NO ☐ If yes, describe_____

Medications, supplements, Vitamins Name	Route (ie. Oral, topical, etc)	Dose	Frequency (ex. 1-2 times/day)

** Add additional page if further space for Medications is needed**

Physicians/practitioners you currently see

NAME	SPECIALTY	REASON

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Family History: particularly Parents, Grandparents, Siblings

☐ Alcoholism	☐ Cancer	☐ High Cholesterol	☐ GERD
☐ Arthritis	☐ Diabetes	☐ Hypertension	☐ Stroke
☐ Heart Disease	☐ Liver Disease	☐ Kidney Disease	☐ Thyroid Disease
Additional History/Notes:			

Number of servings of fruits and vegetables do you have per day? _____
How many times/week do you exercise? _____ Duration? _____ Type? _____

Hearing loss screen

1. Do you have trouble hearing the TV or radio when others don't? ☐ YES ☐ NO
2. Do you have to strain or struggle to hear/understand conversations? ☐ YES ☐ NO

Function screen

1. Do you need help with preparing meals, transportation, shopping, taking your meds, managing finances, or other activities of daily living? ☐ YES ☐ NO
2. Do you live alone? ☐ YES ☐ NO

Fall screen

1. Have you had an injury from a fall in the last year? ☐ YES ☐ NO
2. Have you had more than one fall in the last year? ☐ YES ☐ NO

Home safety screen

1. Does your home have rugs, poor lighting, or a slippery bathtub/shower? ☐ YES ☐ NO
2. Does your home LACK grab bars in bathrooms, handrails on stairs or steps? ☐ YES ☐ NO
3. Does your home LACK functioning smoke alarms? ☐ YES ☐ NO

Advanced Care Planning

1. Do you have an Advanced Directive (living will)? ☐ YES ☐ NO

NOTES:

2. Are you ok with us discussing Advanced Care Planning with you? ☐ YES ☐ NO